Financialization, public funding and the limits to the universality of health

Financeirização, fundo público e os limites à universalidade da saúde

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ABSTRACT This essay aims to reflect on the repercussion of the financialization of the economy for the purpose of establishing a universal health system. From an ontological approach of a historical-materialistic nature, the current situation of the financial dynamics is presented, as well as how it is expressed in the World Bank guidelines for the Brazilian Unified Health System (SUS); revealing the causal mechanisms of underfunding of the SUS, moving it away from full universality; and demonstrating the structural limits of the public fund as an important mediation for the implementation of a universal health system.

KEYWORDS Capitalism. Public policy. Public health. Unified Health System.

RESUMO *Este ensaio possui como objetivo refletir sobre as repercussões da financeirização da economia para a proposta de um sistema universal de saúde. A partir de uma abordagem ontológica de cariz materialista histórico, apresenta-se a conjuntura da dinâmica financeira e como ela se expressa em orientações do Banco Mundial para o Sistema Único de Saúde (SUS); decifram-se os mecanismos causais do subfinanciamento do SUS, afastando-o da universalidade plena; e demonstram-se os limites estruturais do fundo público, enquanto mediação importante à efetivação de um sistema universal de saúde.*

PALAVRAS-CHAVE *Capitalismo. Política pública. Saúde pública. Sistema Único de Saúde.*

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Introduction

A debate is presented on the limits and possibilities of achieving a proposal for a universal health system in view of the financialization process of the economy, considering the mediation of the public fund. It is worth noting that financialization is a process that assumes prominence in contemporary capitalism, given the demand for capital to accelerate its rotation and remedy its inexorable downward trend in the profit rate, when the generic plan is observed.

The case of the Unified Health System (SUS) is considered as a particularity of analysis, since its original proposal incorporates the issue of universal access to health services and actions as one of its doctrinal principles, in order to enable equitable and comprehensive health care, regardless of class, gender, origin, ethnicity, etc. Thus, the aim of this essay is to perform a reflexive analysis on the reverberations of the financialization process in the realization of the universality intended in the SUS proposal, established since the beginning of the Health Reform process in the 1970s and 1980s.

For this purpose, a dialectical reflection is developed striving for a continuous approximation with the object of investigation, with successive, ever deeper instances. For the article presented here, there are two stages of reflection that seek, at first, to address the most immediate dynamics of the problem, taking as a parameter the possible mediations within the framework of current sociability. Secondly, the approach is to seek the deeper determinations of the nature of the public fund in the face of financial capital and its structural limits to the financing of a universal system.

This process of reflection is determined by the movement of the 'real' itself, which lies at the heart of the ontological perspective of historical materialist nature. Mészáros[1(57)] makes an important considerations about this dynamic of reality, in view of a revolutionary horizon, stating that

> the question is, therefore, how to recognize, on the one hand, the demands of immediate temporality without being imprisoned by them; and, on the other hand, how to remain firmly oriented towards the ultimate historical perspectives of the Marxian project without departing from the burning determinations of the immediate present.

The author[1] emphasizes the need to take into account the most radical dimension (in the sense of going to the roots) of reality to transform it, which allows to extend this principle to the question of knowledge production. However, he also warns of the apprehension of important mediations that compose a range of needs of immediate temporality, which, although consigned to the logic of reproduction of the same structure that determines the roots of real problems, need to be deciphered.

In the case of this essay, a conjectural exposition of the problematic was made in the first section, then, in the second section, the problematic about the full implementation of the principle of SUS universality in the context of financialization is discussed, but with a view to possible advances within the framework of immediate temporality. In the last section, progress is made towards the problematization of inherent limits, structural, for the use of public funds in the horizon of health universalization, in the direction of "remain firmly oriented to the ultimate historical perspectives of the Marxian project"[1(57)].

The World Bank's proposal for the reform of the SUS

The World Bank (WB), in a recent document addressed to the Brazilian parliament, entitled

'Proposals for reforms of the Unified Health System', updates its argument, present since the 1990s, when it points to the need for cost-effectiveness adjustments in health actions and services. In it, it stands out that

> there is space for SUS to obtain better results with the current level of public expenditure [...] to make health expenditures more efficient [...] These results corroborate previous evidence showing inefficiencies in the public health system of Brazil[2(4-6)].

The document is based on a broader study, also from the WB, entitled 'A Fair Adjustment: Efficiency and Equity of Public Spending in Brazil'. The study even recognizes that there is underfunding and, moreover, highlights that public investment in health in Brazil is lower than that of many countries, but soon after it abandons/ignores this issue, diverts its causes, accepts it as something given and invests its argument for the conviction that one can do more maintaining the current level of investment:

> Unlike most of its economic partners, more than half of total health expenditure in Brazil is privately funded (individually and privately funded). Public expenditure on health as part of total expenditure on health (48.2%) is significantly lower than the average among OECD countries (73.4%) and lower than its average income partners, is above the average among the Brics countries (46.5%)[3(109)].

Despite this, the emphasis of the direction pointed out by the WB is that it is necessary to improve the efficiency of what it calls 'expenditures' in health, without increasing the values, that is, maintaining the underfinancing. To do so, it argues that reforming the SUS is necessary:

> The potential savings in healthcare expenditures is related to an inefficient scale of provision of services, especially in hospitals. In order to cope with the likely expansion of demand for health services due to the demographic transition and the increasing burden of noncommunicable diseases, the Brazilian health system needs some strategic reforms[3(109)].

Not for nothing has the WB, historically, advocated a model of universality of health that is actually restricted to universal coverage. Thus, it has always been argued that this horizon could be reached, even in developing countries, provided that it observes the cost-effectiveness of actions and prioritizes population segments.

First, it is needed to counter-argue, unraveling the fallacy present in the perspective of universal coverage, which, by no means, coincides with the proposal for full universality of access to health services as conceived in the Health Reform Movement. The original proposal of the SUS consists in the implementation of a universal system, since it presupposes actions and services structured according to the needs of the population, regardless of ethnicity, gender, social class or any other condition. It presupposes health interventions that articulate the individual sphere with the collective, the biological and the social, emphasizing health without forgetting the disease. It is anchored on the premise that health is a right of all to be guaranteed by the State and that, therefore, requires funding consistent with the magnitude of health needs of the entire population[4].

The simple expansion of coverage, even though it reaches everyone, does not guarantee effective access to what is needed, when needed, with resoluteness, equity and integrality. For example, coverage may be restricted to a minimum package of services, including in articulation with the private sector and mechanisms that favor it. Because of this, the WB articulates its proposal of universal coverage to the defense of a system anchored in basic health care, appropriating and reformulating the concept of primary health care.

Primary care consists of a model that presupposes a structure that allows health professionals to anticipate diseases and promote health, 'diving' into the daily life of communities, interacting with other social sectors/areas, in order to bring about more substantial changes in the way of life and, when necessary, addressing basic health problems or enabling system user transit through a more complex service network. Basic care focuses on the most common diseases in the poorest strata of the population, converging well with the idea of a minimum package to be covered by a health system along the lines advocated by the WB.

For Giovanella et al.[5], basic care

> [...] refers to a basic package of essential services and medicines defined in each country, corresponding to a selective approach to achieving basic universalism in developing countries. It is distinguished from the integral approach of universal public systems where it corresponds to the base of the system and must order the care network[5(1766-7)].

It is a poor proposition for the poor, but it goes far from the roots of the poverty-health relationship and, thus, does not even scratch the surface of this structural issue.

Effectively, achieving health coverage for all does not necessarily mean that they are essentially public and resolute in the face of social and health inequities. Worse than that, a focused service structure deviates from the perspective of comprehensiveness, within the horizon of a broad conception of health that attempts to break with the biomedical model.

The SUS's reform proposal of the WB puts an end to the SUS as conceived, precludes any chance of achieving a universal system. To validate this proposal, it hides the roots of the underfunding of the SUS, defending the 'more for less' policy, but which, in reality, is only valid for social policies, in order to guarantee 'always more' for financial capital. Therefore, critically analyzing the financialization process, its relevance in contemporary times and its impacts on the Public Fund is a fundamental step to understand the real causal plot of SUS underfunding.

Financialization of the economy and the usurpation mechanisms of resources of the Public Fund

The neoliberal direction of Brazilian politics gained momentum, above all, in the 1990s, with a series of measures aimed at opening the borders of the Country to international capital, with tax exemption for multinationals, privatization of state companies, indiscriminate use of imports as a mechanism of price control and, in short, prioritization of the economic sphere over social policies, such as health. This is the process called 'counter-reform' by Behring[6], representing a set of reforms in various sectors that weaken the claims expressed in the Federal Constitution (FC) promulgated in 1988.

The advance of neoliberalism in Brazil has in the Washington Consensus, in 1989, a historical landmark responsible for directing the international relations of the Country according to the orientations of financial organizations, such as the WB and the International Monetary Fund (IMF). These guidelines affect the health systems of the countries of late capitalism in an incisive way, as in Brazil. There are, therefore, strong obstacles to the financing of SUS in proportion that it needs in order to be fully universal[7].

Three documents are striking in the beginning of this process: 'Brazil, a new challenge to adult health'[8], in which actions for adult health are focused, through precarious primary care and creating the necessary conditions for the medical-industrial-financial complex to expand through medium and high complexity; the 'World Development Report

1993: Investing in Health'[9], which emphasizes the cost-effectiveness logic, advocating a system that offers some essential services to the poorest and which, in other services, has a link with private sector; and 'The organization, Delivery and Financing of Health Care in Brazil: Agenda for the 1990s', when fiscal concerns are ratified with the health proposal of the 1988 FC.

These were guidelines that distanced SUS from its original proposal in several points. One of the main bottlenecks forged from this dynamic was the underfunding of the system, with judicial-legal confusions about linking resources to health and a level of investment always falling short of the original claim of 10% of Gross Domestic Product (GDP), which restricted its effectiveness as a universal system. It is well known that, the underfunding mechanism of public social policies, especially in social security (health, social security and social assistance), has suffered from the untying of revenues, used to create primary surplus and, thereby, pay interest on public debt[11,12].

For Salvador[11(309)]:

> Holders of public securities use the subterfuge of conditions of 'creditors' of the public sector to hide their real condition as privileged of economic policy, especially fiscal and monetary policy, ongoing in the years of neoliberalism. The public fund transfers huge amounts of resources to these rentiers, which restricts social policies, public investment capacity, and concentrates income and wealth and hinders growth.

Public debt, despite sucking a huge portion from public resources, has been steadily increasing (since only part of the interest is amortized), providing high profit rates for those who buy bonds and who are privileged by exchange rate policy and high interest rates. At the beginning of the Real Plan (July 1994), the reduction in inflation at the expense of rising interest rates caused the public sector net debt to rise from 32.8% to 50% of GDP at the end of the Fernando Henrique Cardoso's government (FHC). In the Lula administration, the false sense of diminishing this debt was created; however, what happened was nothing more than an internalization of the external debt. In other words, external debt decreases, while domestic net debt, which was 38% of GDP in 2003, reached 50% in 2008[11].

The national economic (and political) scenario has undergone intense financialization, which implies the channeling of resources to the financial sphere, aiming to pay interest on public debt. Thus, it was in view of this need (by the interest-bearing capital) that the Untying of Union Revenues (DRU) was created:

> The creation of the Emergency Social Fund, in 1994, which was later called the Fiscal Stabilization Fund and, since 2000, was titled Untying the Union Revenue (DRU) – a name so far maintained, defined, among other aspects, that 20% of the collection of social contributions would be detached from their purpose and available for use by the federal government, far from its object of attachment: social security[12(987)].

In relation to the DRU, Salvador[11] presents data from 2000 to 2007, proving that R$ 278,4 billion were diverted from the social security to the fiscal budget, aiming to generate primary surplus and, thus, create expectations in the financial world that the commitment with debt would be met. Mendes[12], based on data from the National Association of Tax Auditors of Brazil's Federal Internal Revenue – Anfip (2013), analyzes a longer period, finding that

> this mechanism has been causing losses of R$ 578 billion in social security resources, between 1995 and 2012, and its continuity is assured until 2015[12(988)].

In 2013, the untying was R$ 63,4 billion; in 2014, R$ 63,2 billion; and from 2016, its

increase to 30% of the budget was approved[13]. Despite the evident 'leakage' of resources, the responsibility of the DRU for underfunding social policies is omitted, which serves as an excuse for fiscal adjustment, as was done with Constitutional Amendment 95/2016. At this level of analysis, considering the dynamics of social policies within the limits of capitalism, it is clear that the core of the supposed budget tightening is not due to social policies, but to the dynamics of financial capital:

> [...] the federal government insists on commenting on its budgetary rigidity framework. Of the total budget for 2013 (R$ 2,2 trillion), 46% is committed to financial expenses (repayment of debt and interest on debt). Interestingly, it is not explicit here that this has been a priority choice for years. The remaining 54% of the budget is committed to primary expenditures, including compulsory and discretionary expenditures (with protected areas – education, health, 'Brazil without misery', PAC and innovation –, with the other mandatory – servant benefits –, with cuts made in all other areas)[12(988)].

This omission appears in the official data of the National Treasury, as one tries to demonstrate the social security deficit, when, in fact, there would be a positive balance, if it were not for the untying:

> From a 'wrong' conception, the table prepared by the National Treasury presents a 'deficit' in social security in the budget execution made until the last two months of 2007, of R$ 23.4 billion. The false deficit presented is easily dismantled by analyzing the table '9-A from the same publication [from the National Treasury], transcribed in this thesis, as there is a deviation, through the DRU, of R$ 38.6 billion of social security revenues. Therefore, by including the resources 'stolen' by the DRU to the fiscal budget, social security would have a surplus of R$ 15.2 billion, even in the disadvantaged logic of official accounting[11(323)].

Given these priorities, the public fund has been used primarily for the payment of public debt, under the mask of being the mechanism to guarantee the costing of social policies, but which is continuously and permanently stolen. This implies the distortion of universality as a principle of SUS, directing the system in the way advocated by the WB (underfunded), with a package of basic services, focused on diseases and population segments, camouflaged by the fallacy of spending efficiency.

As if this tiny public investment in health was not enough, there is still a significant transfer of resources to private health institutions, especially by municipalities and states. Let's see:

> [...] A brief survey in Siops data of the total expenditure of municipalities with health (2002 to 2007) reveals that spending on outsourced services (legal entities – PJ) represents on average 27% of total municipal spending with health. There is still a significant transfer of resources that has been growing in recent years to private non-profit institutions, transfers that already represented, in 2007, 17.09% of current spending on health [...] Regarding the states, information from Siops indicate that expenditures on third-party services (PJ) represented 25% of the amount of health spending in the states[11(272)].

Once the resources of the Union are transferred from fund to fund to municipalities and states, it can be said that this governmental sphere ends up participating considerably in the financing of private institutions, which is enhanced by the cases of tax exemptions and outsourcing/privatization, determining a direction in the opposite way to the idealized in the Health Reform.

Moreover, considering that these public resources are collected through regressive taxation, the population with the least economic power is twice penalized. According to Salvador[11(11)]:

a) of the amount of R $ 1.04 trillion collected [35.39% of GDP in 2009], most taxes are based on consumption, totaling R$ 569.93 billion, equivalent to 54.90% of the tax collection of the three spheres of government;
b) when taxation on consumption is aggregated with those charged on workers' income, it is revealed that the Brazilian State is financed by salaried workers and lower-income classes that account for 65.58% of the revenues collected by the Company. Union, states, Federal District and municipalities;
c) when comparing taxes and contributions on bank profits to taxes and contributions calculated on employees' incomes, it is observed that while financial entities have paid R$ 22,64 billion in Social Contribution on Net Income (CSLL) and Income Tax on Legal Person (IPRJ), workers paid almost five times more direct taxes than banks (R$ 110.86 billion).

The National Council of State Health Secretaries (Conass)[14], based on data from the Institute of Economic Research Foundation (Fipe) of the University of São Paulo (USP), points out that the tax load represents 48.8% of monthly household income among those who they earn up to two minimum wages, compared to 26.6% among families with a monthly income greater than 30 minimum wages, proving the regressive character of taxation.

Thus, the double penalty for the poorest is that they pay most of the funds from the public fund; however, when these resources return in the form of social security and other policies, they end up with underfunded and unresolved services, such as a universal coverage system based on primary health care. That is, they pay more, receive little and support the enrichment of the public debt renters.

The public fund works as a publican, but for the population with lower purchasing power, especially for the working class, because for the rich, it has been a strategic instrument, since it guarantees the dynamics of contemporary capitalism. Therefore, keeping the SUS underfunded is very functional for interest-bearing capital. Although there is space for improving efficiency in health investment, its underfunding cannot be ignored, the limitations it brings to the proposal as it was conceived, and the real causes and interests behind this process.

Public Fund and health: structural limits and contradictions

The public fund has already been shown to be vital to contemporary, financialized capitalism. Now, this conclusion is expanded to capitalism in general, since credit, interest, state material support, public debt etc. are elements that were already made fundamental for the expanded reproduction of capital in its earliest stages. The fact that they now have greater relevance corresponds to the current needs of capital, in response to its structural crisis, as Mészáros[1] would say, finding a palliative in intensifying the financialization of the economy.

Thus, the public fund is a structural component of the capitalist mode of production, playing an indispensable role in the rotation of capital, especially in times of crisis. As Behring[6(155)] rightly points out,

> a decisive condition for the cycle of capital to occur as production and reproduction is that there is the permanent metamorphosis of the capital-commodity form into capital-money mediated by production and circulation as uninterrupted processes.

This permanent/uninterrupted process constitutes the rotation of capital:

> In it, capital takes its various forms – commodities, money, variable capital, fixed capital, working capital – in time and space, in production and circulation. These are intimately

> interconnected processes which expose the whole system to great upheavals, because it is the nature of capitalist production not to have a 'normal' flow, either for objective reasons, as an example of the mismatch of the processes of metamorphosis of the commodity in money in time and space; it is also for subjective reasons, since the system walks on men's legs, classes, their political action and with very important material impacts, such as a general strike for an indefinite period[6(155)].

This movement of capital is subject to various interferences, changing its speed. A contraction of the rotation time may make part of the advanced surplus value superfluous to social reproduction, which implies the emergence of a plethora of monetary capital. "That is, there is a permanent need for the capital-money system as a whole, but there may be a combination of rotation times that generates excess capital in this form"[6(162-3)], which may result in overproduction and overaccumulation, disrupting rotation.

The crises of overproduction reveal an insoluble contradiction of the capital system: as it is produced in the sense of accumulation through intense private competition, that is to say, it is produced anarchically, a situation arises in which the whole of production exceeds needs of the sphere of circulation, not realizing the crystallized surplus in commodities. Moreover, "in order to produce surplus value it is necessary to sell and the purchasing power is also flattened, in view of a greater extraction of surplus value"[6(172)], accentuating the contradictions between production and circulation, which result and are revealed in the crises.

Accordingly,

> the central issue here is that, in this movement of losses and gains, there is no tendency to equilibrium, and capitalists will always demand additional and liquid capital for their daily management of capital[6(163)].

In the face of this need, credit becomes indispensable, because

> it constitutes additional capital to be mobilized for the management of the scale of production, for the advance of variable capital, for the renewal of fixed capital, and a set of other procedures for the extended reproduction of capital; [or even, in another circumstance,] it constitutes a treasure, which can be transformed into roles and individual bonds of the States, valuing itself around future production[6(165)].

These are mechanisms to ensure the continuity of the rotation of capital, whose point of intervention is the sphere of circulation, through speculative processes that create an apparent autonomy of this sphere from production, as if it were capable of generating capital. However, let us remember that Marx[15] deciphers the origin of surplus value and, therefore, of capital itself, which is only made in the sphere of production, although it cannot dispense with the sphere of movement for its realization.

In this way, hoarding, which allows the injection of capital in the stagnant rotation, consists, merely, of transfer mechanisms and capture of surplus value already produced, but which, being converted from deadweight to virtual capital, being able to produce profit and income, is the reason for the false sense of productive power (of value) in the sphere of circulation[6].

To ensure the effectiveness of these strategies, capital requires the support of the State, creating conditions for its rotation, including through mechanisms for the extraction of surplus value, which should be agglomerated as a public fund and made available for conversion into paper and bonds. As Salvador[16(6)] states,

> this [the continuity of capitalist dynamics] only becomes possible by appropriating increasing portions of public wealth in general,

> or more specifically, public resources that take the state form in capitalist economies and societies.

The public fund, therefore, consists of a 'reservoir' of surplus value available to capital through its permanent need for metamorphosis, especially in crises. Or still, it consists in the "counteracting cause of the downward trend in the profit rate, the intermittent tendency of capitalism that is at the origin of the advent of crises"[6(155)].

Thus, by its function, the public fund carries an intrinsic limitation regarding the financing of health and other social policies. This is where the resources come from to finance these policies (which, one must remember, also contribute to the reproduction of capital, by turning the State into a buyer, being one of the ways to ensure rotation and to fight overproduction), what has been justifying its existence; however, its true very reason rests on the needs of capital rotation, in constant threat by the trend decline of the profit rate.

This means that the public fund is structurally an arena of dispute between social policies and public debt. In times of crisis, or in times of economic backwardness and dependence, this competition ultimately results in underfunded and distorted social policies – especially in the social security field as we saw in the case of SUS – and that penalize workers instead of ensuring that some more immediate needs are met. That is, the financing of social policies is limited by the priority function that the public fund must fulfill before financial capital.

Moreover, it should be stressed that it is a process sustained by productive workers, since it is they, through the exploitation they suffer, that produce the surplus value which turns into profit, interest or income of the land[17]. Thus, regardless of whether taxation is imposed on the poorest or the richest (whether regressive or progressive), it is the workers who pay for the public fund, because all the circulating social wealth from which the state extracts taxes comes from the distribution/sharing of the surplus value that they produced. This condition embodies a typically capitalist contradiction in the relationship between the public fund and the health problem, as indicated below.

Health is a social process, although it manifests itself biologically. It is the result of the way social relations are produced in a given historical period; that is, it is the result of the work process. In capitalism, the labor process is directed to the production of capital through the exploitation of the working class, and determines an extremely troubled social life, marked by social inequality. In this process, workers' health deteriorates directly in the exploitation of their work, but also, due to the lowering of general living conditions, workers or not, end up having their health affected, being subject to various physical and psycho-emotional nuisances[18].

The problem of health is constituted, then, as a result of the labor process as it occurs in capitalism (say, process of valorization). Degrading health conditions, at the same time, corresponds to a consequence and a requirement for the existence of capital itself, since it is produced only in the exploitation of labor, which is not done without sweat and bloodshed[19].

Concurrently, actions and public services aimed at improving health conditions are financed through public fund resources. This contradiction is established: the production of surplus value creates the material conditions for the financing of health actions at the same time that, by the inherent dynamics of its production, it degrades human life. This means that the same process that produces wealth converted into health resources in the public fund is responsible for the poor sanitary conditions, constituting a true sisifism.

Thus, it can be seen that the relationship between public fund and health, under the aegis of capital, has limits and contradictions ontologically insurmountable. Therefore, the State must continue to be tensioned in order to guarantee greater resources for public health

policies, but it must be borne in mind that this has a limit, since the full universalization of health depends on a concomitant transformation of society since its roots, eliminating the structural limits that consign the health system to the dynamics of capital.

Final considerations

It was found that the WB plays a leading role in conducting the hypertrophy process of financialization of the economy and achieving the international objectives of neoliberalism. As far as health is concerned, its orientations focus considerably on the level of funding of systems that aim to achieve full universality.

For this purpose, this financial institution, through a theoretical-conceptual maneuver (ideologically based), shifts the conception of universal system and primary health care, opening space for the spread of the idea of universal coverage, effected through primary health care.

In the Brazilian case, it was found that the chronic nature of health underfunding has in DRU one of its main mechanisms, because, from it, the public fund is looted. Thus, the resources that should finance social security end up nourishing the public debt. Such condition removes the SUS from its original proposal and brings it closer to what the WB advocates.

A process of rupture with this mechanism is necessary, both from the point of view of immediate temporality, as more resources are needed and possible for SUS; and from the point of view of the last historical perspectives of the revolutionary project, upon which the full realization of the universalization of health depends, in view of the structural limits of the public fund before capital.

Collaborators

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